Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LOWES HOME CENTERS INC

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-11-4772-01

MFDR Date Received
August 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial. This denial is not in compliance with Rule §133.3."

Amount in Dispute: $121.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill for the date of service 2/10/11 indicates that the doctor who performed the treatment was Carl C. Davis, J., M.D. It also states that Carl C. Davis, Jr., M.D. was the referring doctor. As Dr. Davis is not the treating doctor, nor was he referred by the treating doctor, the bill was denied."

Response Submitted by: Downs, Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2011	99213 and 99080	$121.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §180.22 sets out the Health Care Provider Roles and Responsibilities.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 665 – Description not available
   - 96 – Non-covered charge(s).
   - 850-665 – Non covered services. Carl Davis is not the treating physician

Issues

1. Is the healthcare in dispute approved or recommended by the injured employee's treating physician?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code at §408.021(c) states that —all health care must be approved or recommended by the injured workers' treating physician."

   Division rule at 28 TAC §180.22(c) states that —The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care of an injured employee's (employee) compensable injury. The treating doctor shall: except in the case of an emergency, approve or recommend all health care rendered to the employee including, but not limited to, medically reasonable and necessary treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers as defined in this section. . ."
   - Review of the Division of Worker's Compensation records lists Dr. Oguneo as the treating doctor of record.
   - Review of the CMS-1500, box 31 lists Carl C. Davis, Jr., MD as the physician or supplier, further review of the CMS-1500, box 17 lists Dr. Carl C. Davis, Jr., MD as the referring provider or other source.
   - No documentation was found to support that the disputed services were approved or recommended by the injured worker's treating doctor. The Division concludes that the requestor has not meet the requirements of Division rule at 28 Texas Administrative Code §180.22(c).
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement of the disputed charges.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.